

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155070		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 07/06/2011	
NAME OF PROVIDER OR SUPPLIER GREEN VALLEY CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3118 GREEN VALLEY ROAD NEW ALBANY, IN 47150			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K0000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 07/06/11</p> <p>Facility Number: 000028 Provider Number: 155070 AIM Number: 100275370</p> <p>Surveyor: Mark Bugni, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Green Valley Care Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (000) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and single station smoke detection in all resident sleeping rooms. The facility has</p>			K0000	<p>This plan of Correction is submitted under Federal and State regulations and status applicable to long-term-care providers. This Plan of Correction does not constitute an admission of liability on the part of the facility and such liability is hereby denied. The submission of this plan does not constitute an agreement by the facility that the surveyors' findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies are cited correctly. Furthermore, we request this Plan of Correction serve as our credible allegation of compliance.</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155070		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 07/06/2011	
NAME OF PROVIDER OR SUPPLIER GREEN VALLEY CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3118 GREEN VALLEY ROAD NEW ALBANY, IN47150			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K0027 SS=E	<p>a capacity of 242 and had a census of 119 at the time of this visit.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 07/12/11.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following</p> <p>Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 Based on observation and interview, the facility failed to ensure 4 of 17 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC 19.3.7.6 requires doors in smoke barriers shall comply with Section 8.3.4. 8.3.4.1 requires doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch. This deficient practice could affect 18 residents who reside on the 200 Hall, 21 residents who reside on the 400 Hall</p>			K0027	<p>It is the practice of this facility to assure that the doors in our sprinklered building resist the passage of smoke for at least 20 minutes. The gap along the 200 Hall and 400 Hall Set of doors has been repaired. Repairs were performed by the facility maintenance department. The Administration Hall doors will be replaced with new doors. Replacement doors have been ordered and will be installed by SafeCare. Facility smoke barrier doors were inspected for needed repairs and corrected if indicated. Maintenance Director or</p>		08/22/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155070		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 07/06/2011	
NAME OF PROVIDER OR SUPPLIER GREEN VALLEY CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3118 GREEN VALLEY ROAD NEW ALBANY, IN 47150			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>and any resident using the Administration Hall.</p> <p>Findings include:</p> <p>Based on observations on 07/06/11 during a tour of the facility from 8:50 a.m. to 12:10 p.m. with the maintenance director, the 200 Hall set of smoke barrier doors and the 400 Hall set of smoke barrier doors each had a one inch gap where the two pairs of doors met. The Administration Hall single smoke barrier door by the staff development office, and the Administration Hall single smoke barrier door near the conference room each had a one inch gap along the latching sides of the doors. This was verified by the maintenance director at the time of observations.</p> <p>3.1-19(b)</p>				<p>designee will conduct quarterly inspections of the smoke/fire doors to ensure that when closed, there is only the minimum clearance necessary for proper operation which is defined as 1/8 inch. We respectfully request an extension on the expected completion date of 8/5/11 secondary to having to order the necessary materials. Our estimated completion date is August 22, 2011.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155070		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 07/06/2011	
NAME OF PROVIDER OR SUPPLIER GREEN VALLEY CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3118 GREEN VALLEY ROAD NEW ALBANY, IN47150			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K0029 SS=E	<p>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>1. Based on observation and interview, the facility failed to ensure the corridor door to 1 of 23 hazardous areas such as a combustible storage room over 50 square feet in size was provided with a door equipped with a self closing device which would cause the doors to automatically close and latch into the door frame. This deficient practice could affect 18 residents who reside on the 200 Hall.</p> <p>Findings include:</p> <p>Based on observation on 07/06/11 during a tour of the facility from 8:50 a.m. to 12:05 p.m. with the maintenance director, the 200 Hall therapy storage room which measured three hundred twenty square feet in size and had three shelves of plastic and paper general nursing supplies was not equipped with a self closing device on the door. This was verified by the maintenance director at the time of observations.</p>			K0029	<p>A self-closing device has been installed on the 200 Hall Therapy Storage Room Door. The wooden shelf unit has been removed and the storage containers were placed in an appropriate area.</p>		08/05/2011

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/28/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155070		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 07/06/2011	
NAME OF PROVIDER OR SUPPLIER GREEN VALLEY CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3118 GREEN VALLEY ROAD NEW ALBANY, IN47150			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 23 sprinklered hazardous areas such as a combustible storage area was enclosed with smoke resistant partitions and a self closing door. This deficient practice could affect 18 residents who reside on the 200 Hall. Findings include: Based on observation on 07/06/11 during a tour of the facility from 8:50 a.m. to 12:05 p.m. with the maintenance director, the basement corridor next to the maintenance director office had three shelves of combustible plastic storage containers filled with plastic and paper holiday decorations stored on a wooden shelf unit in the corridor. 3.1-19(b)						